## Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER  390153  NAME OF PROVIDER OR SUPPLIER: PAOLI HOSPITAL  STATE LICENSE NUMBER: 161801		STREET ADDRESS,	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: _00 _ B. WING:  , CITY, STATE, ZIP CODE:  ANCASTER AVENUE  9301		(X3) DATE SURVEY COMPLETED: 07/24/2023		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  CX5) COMPLETE DATE		COMPLETE
P 0000	This report is for replaction to the Paoli Hospital- Cowere in full compliance Pennsylvania Departm Regulations for Hospit Subparts A and B, Nov June 1998.	9, 2023. ed they ents of the s and rt IV,	P 0000				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

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## **Certified End Page**

## **PAOLI HOSPITAL**

STATE LICENSE NUMBER: 161801 SURVEY EXIT DATE: 07/24/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY